

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Registration District No. 859 Primary Registration District No. 6130

1. PLACE OF DEATH:  
(a) County Janey Adams  
(b) City or town Hollister Mo  
(c) Name of hospital or institution:  
died on Road to hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3  
In this community 15 yr - 4 mo - 8 days  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Voncille Beard  
8. (b) If veteran, name war no 8. (c) Social Security No. \_\_\_\_\_  
4. Sex Female 5. Color or race White  
6. (a) Single, widow, married, divorced, Widow  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased April 11 1925  
(Month) (Day) (Year)  
8. AGE: Years 15 Months 4 Days 8 If less than one day hr. min.

9. Birthplace Hollister Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation Child

11. Industry or business \_\_\_\_\_  
MOTHER FATHER { 12. Name O. L. Beard  
13. Birthplace Janey Co Mo  
14. Maiden name Lena Hoover  
15. Birthplace Janey Co Mo

16. (a) Informant's own signature Jewell Beard  
(b) Address Hollister Mo

17. (a) Funeral (b) Date thereof Aug 20 40  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Edgar Valley Janey

18. (a) Signature of funeral director A. J. Hammett  
(b) Address Branson Mo

19. (a) 8-20-40 (b) John A. Baxter  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County Janey  
(c) City or town Hollister  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A.? no years.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Aug day 19th year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from Aug 19 1940 to Aug 19 1940, 1940, that I last saw her alive on Aug 19 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Internal injuries due to being run over by a truck  
Duration 2 hours

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) accident  
(b) Date of occurrence 8-19-1940  
(c) Where did injury occur? Hollister Janey - Mo  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? on farm  
While at work? no (Specify type of place) (e) Means of injury truck  
23. Signature Dr. Harry T. Swann (M. D. or other) MD  
Address Branson Mo Date signed 8/20/40

RECEIVED

District Health Officer No. 8,

District File Number 940-2510

Date Filed SEP 03 1940

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**